CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

February 28, 1997 / Vol. 46 / No. 8

MMWR™
MORBIDITY AND MORTALITY WEEKLY REPORT

Update: Trends in AIDS Incidence, Deaths, and Prevalence — United States, 1996

The national acquired immunodeficiency syndrome (AIDS) surveillance system is used to describe the impact of HIV-related morbidity and death in the United States. This report presents trends in AIDS incidence during 1996 and describes recent declines in deaths among persons reported with AIDS (AIDS deaths) and increases in AIDS prevalence.*

Cumulative AIDS cases among persons aged ≥13 years reported to CDC based on the 1993 expanded surveillance case definition from the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories were analyzed by year of report, race/ethnicity, and mode of risk/exposure (*1*). Estimates of AIDS incidence and deaths were adjusted for the effects of delays in reporting. For analyses by mode of risk/exposure, estimates were adjusted for the anticipated reclassification of cases initially reported without an HIV risk/exposure (*1*). To adjust for the expansion of the reporting criteria in 1993, estimates of the incidence of AIDS-opportunistic illnesses (OIs) were calculated from the sum of cases diagnosed with an AIDS-OI and the estimated dates of an AIDS-OI diagnosis for cases reported based on immunologic criteria† (*1*). AIDS-OI incidence was estimated quarterly through June 1996, the most recent period for which reliable estimates were available. Estimates of AIDS-OI incidence rates per 100,000 population were based on 1995 population estimates from the Bureau of the Census. Deaths among persons with AIDS were identified by review of medical records and death certificates and include both deaths from AIDS and from other causes. AIDS prevalence was estimated from cumulative AIDS incidence minus cumulative deaths.

Reported AIDS Cases

From 1981 through 1996, a total of 573,800 persons aged ≥13 years with AIDS were reported to CDC by state and local health departments (Table 1). The expansion of the AIDS surveillance case definition in 1993 resulted in a large increase in reported cases

*Single copies of this report will be available until February 28, 1998, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

†The immunologic criteria that were added to the AIDS case definition in 1993 were CD4+ T-lymphocyte count <200 cells/μL or CD4+ T-lymphocyte percentage of total lymphocytes of <14.

TABLE 1. Number and percentage of persons aged ≥13 years reported with AIDS, by sex and race/ethnicity — United States, 1981–1996

Characteristic	Year of report											
	1992		1993*		1994		1995		1996		1981–1996	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex												
Male	40,330	(86)	87,945	(84)	64,730	(82)	59,285	(81)	54,653	(80)	488,300	(85)
Female	6,307	(14)	16,671	(16)	13,830	(18)	13,682	(19)	13,820	(20)	85,500	(15)
Race/Ethnicity												
White, non-Hispanic	22,320	(48)	47,468	(45)	32,677	(42)	29,402	(40)	26,229	(38)	267,487	(47)
Black, non-Hispanic	15,576	(33)	37,523	(36)	30,373	(39)	28,729	(39)	28,346	(41)	198,780	(35)
Hispanic	8,223	(18)	18,410	(18)	14,612	(19)	13,961	(19)	12,966	(19)	101,253	(18)
Asian/Pacific Islander	334	(<1)	761	(<1)	573	(<1)	558	(<1)	561	(<1)	4,090	(<1)
American Indian/ Alaskan Native	121	(<1)	369	(<1)	246	(<1)	237	(<1)	207	(<1)	1,544	(<1)
Total†	**46,637**	**(100)**	**104,616**	**(100)**	**78,560**	**(100)**	**72,967**	**(100)**	**68,473**	**(100)**	**573,800**	**(100)**

*Year the expanded AIDS surveillance case definition was implemented.
†Totals inlcude persons with unknown or missing race/ethnicity.

AIDS — Continued

during 1993 followed by declines in numbers of AIDS cases reported each year from 1994 through 1996. The 68,473 AIDS cases reported during 1996 was substantially higher (47%) than the number reported during 1992.

From 1992 through 1996, non-Hispanic blacks, Hispanics, and women accounted for increasing proportions of persons reported with AIDS. In 1996, non-Hispanic blacks accounted for 41% of adults reported with AIDS, exceeding for the first time the proportion who were non-Hispanic white, and women accounted for an all-time high of 20% of adults reported with AIDS.

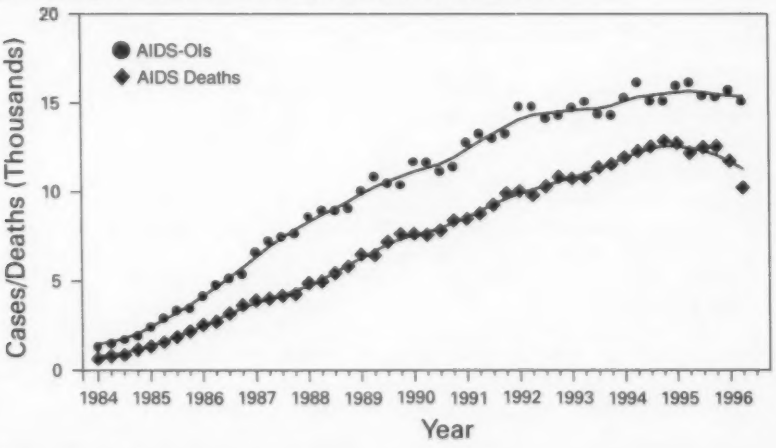
AIDS-OI Incidence

In 1995, AIDS-OIs were diagnosed in an estimated 62,200 persons, an increase of 2% over the estimate for 1994 (61,200) (Figure 1). From January 1994 through June 1996, the quarterly incidence of AIDS-OIs was stable (mean: 15,200 cases per quarter).

During 1995, estimated AIDS-OI incidence rates per 100,000 population were approximately sevenfold higher among non-Hispanic blacks (99) and threefold higher among Hispanics (50) than among non-Hispanic whites (15). Estimated rates were lowest among American Indians/Alaskan Natives (14) and Asians/Pacific Islanders (6) and were nearly five-fold greater among men (48) than among women (10).

From 1994 through 1995, estimated AIDS-OI incidence was approximately constant (a decrease of 2%) among men who have sex with men (MSM) (Figure 2) and among heterosexual injecting-drug users (IDUs) (an increase of 2%) (Figure 3), but increased substantially among persons infected through heterosexual contact (17%) (Figure 4).

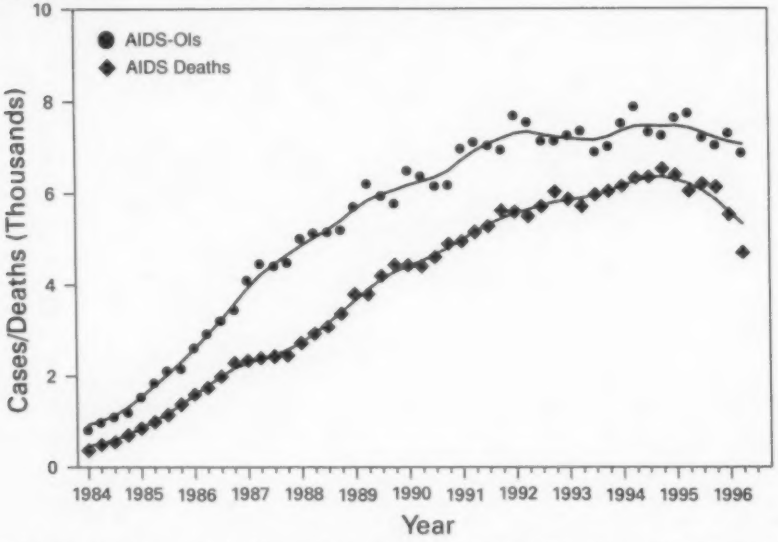
FIGURE 1. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons with AIDS (AIDS deaths)*, adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996†



*Estimates include persons aged <13 years.
†Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

AIDS — Continued

FIGURE 2. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons aged ≥13 years with AIDS (AIDS deaths), by exposure category (men who have sex with men), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

Of the 30,100 persons in whom AIDS-OIs were diagnosed during January–June 1996, 46% were MSM, 29% were IDUs, and 17% were infected through heterosexual contact.

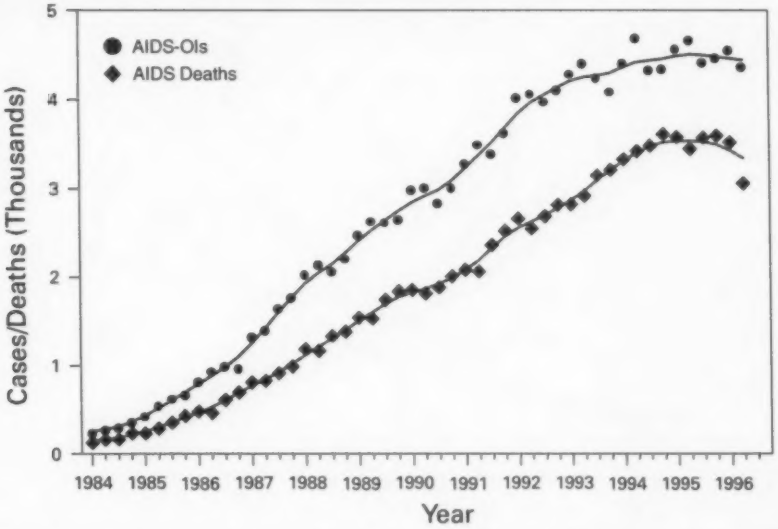
Deaths Among Persons Reported with AIDS

The estimated number of deaths among persons reported with AIDS increased steadily through 1994 (approximately 49,600 deaths among persons with AIDS during 1994) (Figure 1) but increased only slightly in 1995 (approximately 50,000 deaths). During January–June 1996, the estimated number of AIDS deaths (22,000) was 13% less than that estimated during January–June 1995 (24,900), and the number of deaths declined in each of the four regions of the United States (Northeast [15%], South [8%], Midwest [11%], and West [16%])[§]. The number of AIDS deaths also declined among all racial/ethnic groups (non-Hispanic whites [21%], non-Hispanic blacks [2%], Hispanics [10%], Asians/Pacific Islanders [6%], and American Indians/Alaskan Natives [32%])

[§]Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

AIDS — Continued

FIGURE 3. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons aged ≥13 years with AIDS (AIDS deaths), by exposure category (injecting-drug use), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

and among men (15%) but increased 3% among women. By risk/exposure category, deaths declined 18% among MSM (Figure 2) and 6% among IDUs (Figure 3) but increased 3% among persons infected through heterosexual contact (Figure 4), the only risk/exposure group with large increases in AIDS-OI incidence during 1995.

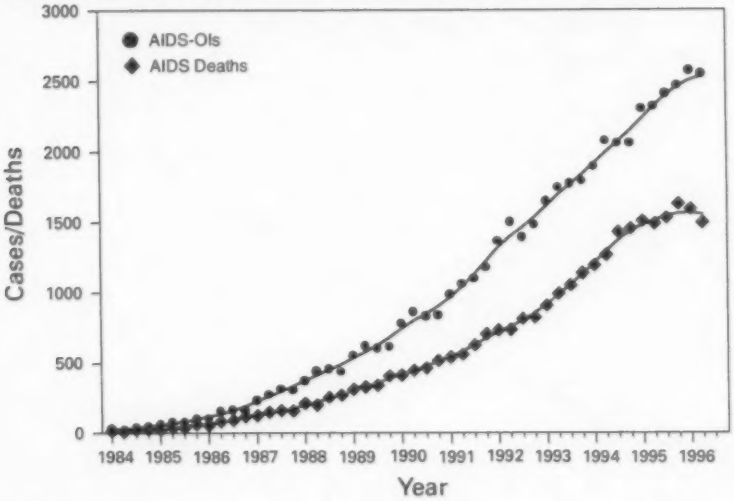
AIDS Prevalence

As of June 1996, the estimated prevalence of AIDS was 223,000 U.S. residents aged ≥13 years (Figure 5), representing increases of 10% and 65% since mid-1995 and January 1993, respectively. Of prevalent cases of AIDS, 82% were among men; 43%, non-Hispanic whites; 38%, non-Hispanic blacks; and 19%, Hispanics. By risk/exposure category, MSM accounted for the largest number of prevalent cases of AIDS (44%), followed by IDUs (26%) and persons infected through heterosexual contact (12%); all other risk/exposure groups¶ combined accounted for 18% of prevalent cases of AIDS. The largest proportionate increase in AIDS prevalence from June 1995 through June 1996 occurred among persons infected through heterosexual contact (19%) while the largest absolute increase occurred among MSM (5100).

¶Includes men who reported both having sex with men and injecting-drug use, persons with hemophilia/coagulation disorders, transfusion recipients, and persons with other or no risks reported.

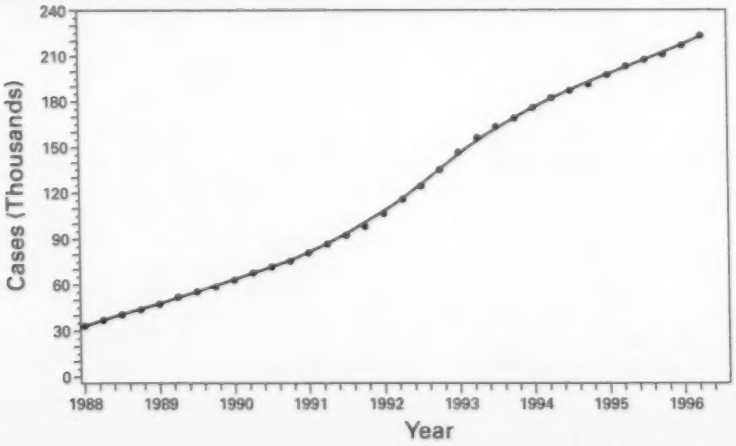
AIDS — Continued

FIGURE 4. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons aged ≥13 years with AIDS (AIDS deaths), by exposure category (HIV infection acquired through heterosexual contact), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

FIGURE 5. Number of prevalent AIDS cases among persons aged ≥13 years, adjusted for delays in reporting, by quarter year — United States, 1988–June 1996*



*Points represent quarterly prevalence; the line represents "smoothed" prevalence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases or AIDS deaths.

AIDS — Continued

Reported by: State and local health depts. Div of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, CDC.

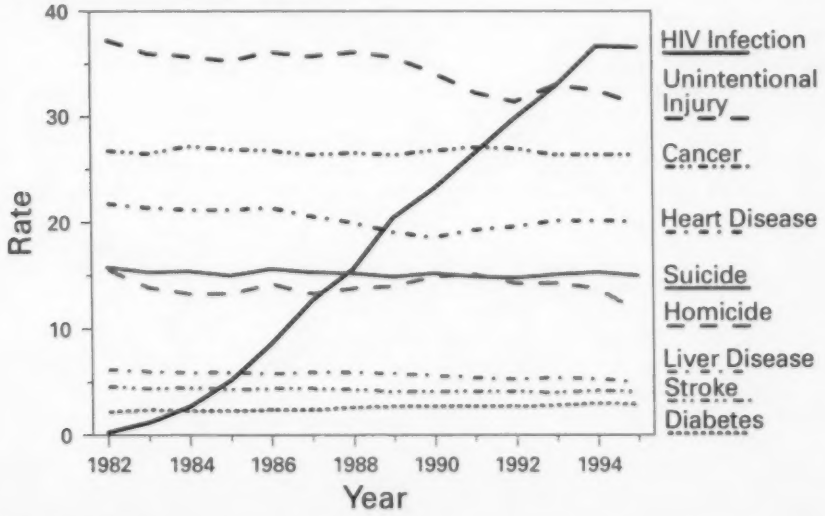
Editorial Note: The findings in this report document a substantial increase in AIDS prevalence in the United States. Prevalence is a function of both the rate of new infections and the duration of illness. The increase in AIDS prevalence reflects declines in AIDS deaths and stable AIDS incidence. The increased prevalence of AIDS indicates the need for medical and other services for persons with HIV infection and for prevention programs to reduce the number of persons becoming infected with HIV.

The leveling of AIDS-OI incidence nationally in 1995 was preceded by a gradual deceleration in the rate of increase of new AIDS diagnoses during previous years (*1*). Similar trends have been documented among MSM and IDUs in clinic-based HIV-seroprevalence surveys (*2*). However, the incidence of cases associated with heterosexual contact has continued to increase, primarily reflecting transmission from the large population of IDUs with HIV/AIDS to their heterosexual partners.

For the first time, deaths among persons with AIDS have decreased substantially. This finding is consistent with recent reports, based on death-certificate data, of declines in deaths from HIV infection in New York City (*3*) and nationally (*4*). Despite these trends, during 1995 HIV infection remained the leading cause of death among persons aged 25–44 years (Figure 6), accounting for 19% of deaths from all causes in this age group.

The decrease in AIDS deaths reflects both the leveling of AIDS-OI incidence and improved survival among persons with AIDS. Increased survival reflects recent im-

FIGURE 6. Death rates* for leading causes of death among persons aged 25–44 years, by year — United States, 1982–1995†



*Per 100,000 population.

†Based on underlying cause of death reported on death certificates, using final data for 1982–1994 and preliminary data for 1995.

AIDS — Continued

provements in medical care, the use of combination therapy with antiretroviral agents, and increasing use of prophylactic drugs to prevent secondary AIDS-OIs (*5*). In addition, the widespread availability of protease inhibitors, approved by the Food and Drug Administration in 1996, may further improve survival (*6*).

The higher AIDS-OI incidence rates among non-Hispanic blacks and Hispanics than among non-Hispanic whites may reflect reduced access to health care associated with disadvantaged socioeconomic status, cultural or language barriers that may limit access to prevention information, and differences in HIV risk behaviors (*7*). The number of AIDS deaths did not decrease among women or persons infected through heterosexual contact, reflecting, in part, continued increases in AIDS incidence and differences in access to treatment, which may vary by sex, region, race/ethnicity, and risk/exposure. To assist prevention efforts and treatment services, surveillance systems are being developed to assess access to counseling, testing, and care.

Monitoring AIDS prevalence will help direct resources to persons most in need of treatment for severe HIV disease. However, because the clinical status of most HIV-infected persons has not yet progressed to AIDS (*8*), AIDS prevalence underestimates the total number of HIV-infected persons in need of related services. Advances in treatment and improved survival also will affect efforts to monitor the HIV epidemic based on the current AIDS surveillance definition and, therefore, will require surveillance systems that are less sensitive to changes in the progression of HIV disease. Among the 26 states that conducted surveillance for cases of both HIV infection and AIDS in 1996, prevalence of HIV and AIDS among reported cases (126,491) was 2.5-fold higher than the prevalence of AIDS (51,217) (*1*). However, this represents a minimum estimate of HIV prevalence in these states because not all HIV-infected persons seek testing and some persons are tested anonymously.

The Council of State and Territorial Epidemiologists has recommended that all states consider implementing surveillance for HIV infection and AIDS (*9*). Population-based surveillance for both HIV and AIDS provides a more complete measure of the number of HIV-infected persons and a more timely measure to detect emerging patterns of HIV transmission than does AIDS surveillance alone. CDC provides technical assistance and funding to areas that conduct both HIV and AIDS case surveillance. CDC also supports research to develop optimal surveillance methods that meet the need for important behavioral, biomedical, and treatment data for persons with HIV and AIDS and that address public health and community concerns about factors that may influence decision-making regarding testing or treatment.

Future trends in the HIV/AIDS epidemic in the United States will reflect the effectiveness of programs to prevent new HIV infections, to promote timely diagnosis, and to continue improving clinical management. CDC has established as a primary prevention strategy efforts to involve affected communities in planning and evaluating HIV-prevention programs (*10*). To continue to provide data for planning, directing, and evaluating HIV prevention and care services at the federal, state, and local levels, HIV/AIDS surveillance systems must adapt to changes in the diagnosis and clinical management of HIV and AIDS.

AIDS — Continued

References

1. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, 1996:3–4,20,30–3. (Vol 8, no. 1).
2. CDC. National HIV serosurveillance summary: results through 1992. Atlanta: US Department of Health and Human Service, Public Health Service, CDC, November 1993.
3. Chiasson M, Berenson L, Li W, Schwartz S, Mojica B, Hamburg M. Declining AIDS mortality in New York City [Abstract]. In: Program and abstracts of the IV Conference on Retroviruses and Opportunistic Infections, 1997. Alexandria, Virginia: Infectious Diseases Society of America for Retrovirology and Human Health, 1997.
4. National Center for Health Statistics. Births, marriages, divorces, and deaths for July 1996. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1997. (Monthly vital statistics report; vol. 45, no. 7, suppl).
5. Jones JL, Hanson DL, Ward JW, Kaplan JE. Incidence trends in AIDS-related opportunistic illnesses in injecting drug users and men who have sex with men [Abstract]. Vancouver, British Columbia: XI International Conference on AIDS, 1996.
6. Carpenter CCJ, Fischl MA, Hammer SM, et al. Antiretroviral therapy for HIV infection in 1996: recommendations of an international panel. JAMA 1996;276:146–54.
7. CDC. AIDS among racial/ethnic minorities—United States,1993. MMWR 1994;43:644–7,653–5.
8. Karon JM, Rosenberg PS, McQuillan G, Khare M, Gwinn M, Petersen L. Prevalence of HIV infection in the United States, 1984 to 1992. JAMA 1996;276:126–31.
9. Council of State and Territorial Epidemiologists. CSTE: position statement 2. Surveillance of HIV infection and disease. Atlanta: Council of State and Territorial Epidemiologists, 1991.
10. Valdiserri RO, Aultman TV, Curran JW. Community planning: a national strategy to improve HIV prevention programs. J Community Health 1995;20:87–100.

Update: Influenza Activity — United States, 1996–97 Season

Influenza activity in the United States has continued to decline since mid-January 1997. The predominant viruses have been influenza type A (H3N2), although the proportion of influenza B isolates has increased since the week ending January 18. This report summarizes influenza activity in the United States from September 29, 1996, through the week ending February 15, 1997.

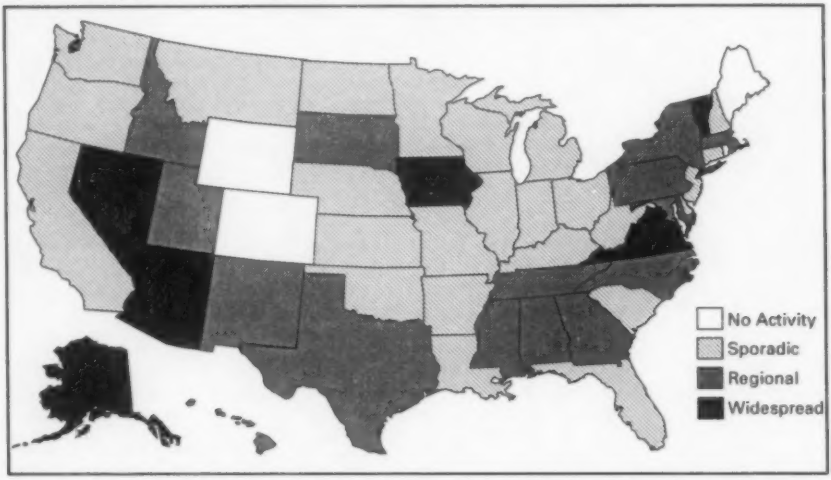
The proportion of patients who visited 120 U.S. sentinel physicians for influenza-like illness (ILI) peaked at 7% from mid-December through the first week of January and was 3% of total visits by the week ending February 15, 1997. The proportion of visits for ILI had remained at or below the baseline level of 3% since the week ending January 25, 1997; however, the proportion of ILI visits had not yet reached baseline levels in the West South Central and Pacific regions through the week ending February 15, 1997.

Influenza activity* has decreased since the week ending December 28, 1996, when state and territorial epidemiologists in 38 states reported either widespread or regional activity. For the week ending February 15, 1997, either widespread or regional influenza activity was reported in 21 states and sporadic activity was reported in 25 states and the District of Columbia (Figure 1). None of the states in the East North Central region reported regional or widespread activity for the week ending February 15.

*Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring ILI or culture-confirmed influenza with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of ≥50% of the state's total population.

Influenza Activity — Continued

FIGURE 1. Level of influenza activity* reported by state and territorial epidemiologists — United States, week ending February 15, 1997



*Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring influenza-like illness (ILI) or culture-confirmed influenza with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of ≥50% of the state's total population.

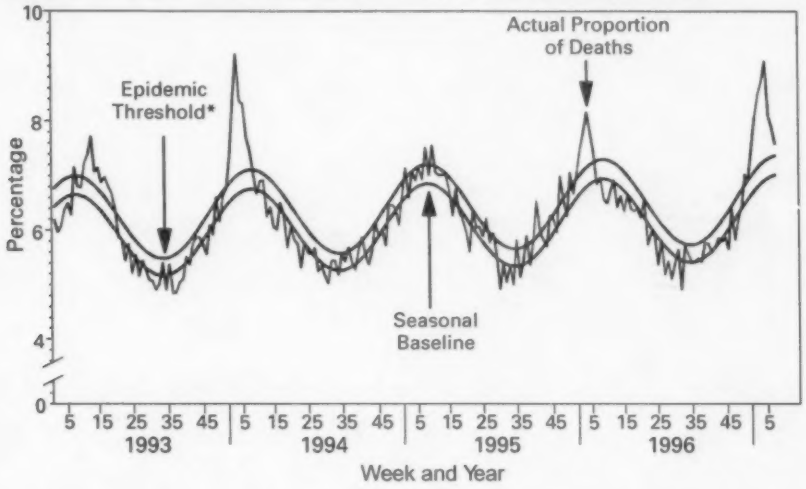
The proportion of deaths attributed to pneumonia and influenza (P&I) among 122 U.S. cities exceeded the epidemic threshold† during the week ending December 14, 1996, and peaked at 9.1% during the week ending January 25, 1997. Since then, although the proportion of P&I deaths has declined, it has remained above the epidemic threshold for 10 consecutive weeks through the week ending February 15, 1997 (Figure 2).

From September 29, 1996, through February 15, 1997, World Health Organization (WHO) collaborating laboratories in the United States reported 5050 (19.1%) influenza isolates from the total 26,430 specimens submitted for respiratory virus testing: 4714 (93.4%) were type A, and 336 (6.7%) were type B. All 1866 influenza A isolates subtyped have been A(H3N2) viruses; thus far, no A(H1N1) viruses have been reported in the United States during the 1996–97 influenza season. From September 29, 1996, through December 28, 1996, a total of 38 (1.4%) of 2811 influenza isolates were type B. Although the total number of influenza viruses isolated has declined since then, the proportion of influenza B isolates has increased. During January 26–February 15, a total of 166 (42.5%) of the 391 reported influenza isolates were type B. At least one type B isolate has been reported from each region.

†The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

Influenza Activity — Continued

FIGURE 2. Weekly pneumonia and influenza (P&I) mortality as a percentage of all deaths in 122 cities — United States, January 1, 1993–February 15, 1997



*The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of death from P&I since 1983.

Reported by: Participating state and territorial epidemiologists and state public health laboratory directors. World Health Organization collaborating laboratories. Sentinel Physicians Influenza Surveillance System. Influenza Br and WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: All four components of the influenza surveillance system indicate that influenza activity is declining in the United States. However, as of February 15, some states continued reporting widespread activity. Although 93% of influenza isolates for this season have been type A, an increasing proportion of influenza viruses isolated by WHO collaborating laboratories since January 1997 have been influenza type B viruses.

Rapid antigen testing of nasopharyngeal swab specimens for influenza A is commercially available in many areas. The timely diagnosis of influenza A can be useful in inpatient and clinic settings to guide the selection of antiviral drugs (amantadine or rimantadine) for prophylaxis or treatment of persons at high-risk for influenza A-related complications. These drugs are 70%–90% effective in preventing influenza A infections and can reduce the severity and duration of symptoms from influenza A when administered within 48 hours of illness onset. However, they are not effective against influenza type B viruses.

Early recognition of influenza A outbreaks is especially important in institutions that provide care for elderly persons because infection can spread rapidly and the impact of influenza A can be particularly severe in these settings. Administration of

Influenza Activity — Continued

amantadine or rimantadine early in the course of an influenza A outbreak can control further spread of infection. Chronic-care facilities should know before an outbreak occurs which laboratories in their area perform influenza A rapid antigen testing (*1–3*).

Influenza surveillance data collected by CDC is updated weekly throughout the influenza season. Information is available through the CDC voice information system, telephone (404) 332-4551, or the fax information system, telephone (404) 332-4565, by requesting document number 361100.

References

1. Gomolin IH, Leib HB, Arden NH, Sherman FT. Control of influenza outbreaks in the nursing home: guidelines for diagnosis and management. J Am Geriatr Soc 1995;43:71–4.
2. Leonardi GP, Leib H, Birkhead GS, Smith C, Costello P, Conron W. Comparison of rapid detection methods for influenza A virus and their value in health-care management of institutionalized geriatric patients. J Clin Microbiol 1994;32:70–4.
3. ACIP. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1996;45(no. RR-5).

National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19–35 Months — United States, January–December 1995

The National Immunization Survey (NIS) is an ongoing survey that provides national estimates of vaccination coverage among children aged 19–35 months based on data for the most recent 12 months for each of the 50 states and for 28 selected urban areas, including the District of Columbia (*1–3*). CDC implemented NIS in April 1994 to monitor current vaccination coverage levels as one element of the five-part Childhood Immunization Initiative (CII) (Table 1), a national strategy to attain high vaccination coverage among children during the first 2 years of life (*1,4*). This report presents NIS findings for 1995, which indicate that 1995 CII interim national coverage goals were achieved or exceeded for all routinely recommended childhood vaccines.*

NIS collects data in two phases. In the first phase, during each quarter, a random sample of telephone numbers is contacted in each survey area and a screening questionnaire is administered to respondents aged ≥18 years to identify households with one or more children aged 19–35 months†. Vaccination information is collected from all participating households with age-eligible children. All respondents are asked to refer to written vaccination records; however, reports from recall also are used. During 1995, approximately 1.6 million telephone numbers were called, and 31,997 interviews were completed (an average of 410 interviews per survey site). The overall response rate for eligible households was 69% (range: 53%–86% among the 78 survey sites). Survey responses were weighted to account for household nonresponse, natality data, and the lower vaccination coverage among children in households without telephones (*1,2,5*; CDC, unpublished data, 1994).

*Diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoids (DTP/DT), poliovirus vaccine, measles-mumps-rubella vaccine (MMR), *Haemophilus influenzae* type b vaccine (Hib), and hepatitis B vaccine. As during the two preceding reporting periods, MMR reflects any measles-containing vaccine (MCV).

†For this reporting period (January–December 1995), NIS included children born during February 1992–May 1994 (median age: 27 months).

Vaccination Coverage Levels — Continued

TABLE 1. Childhood Immunization Initiative goals and vaccination coverage levels among children aged 19–35 months, by selected vaccines — United States, National Immunization Survey, 1995

Vaccine/Dose	Childhood Immunization Initiative		National Immunization Survey					
			July 1994–June 1995*		January–December 1995		October–December 1995	
	1995 Goal	1996 Goal	%	(95% CI†)	%	(95% CI)	%	(95% CI)
DTP/DT§								
≥3 Doses	87%	90%	94%	(±0.5%)	95%	(±0.6%)	95%	(±0.7%)
≥4 Doses	—	—	78%	(±1.0%)	79%	(±1.0%)	80%	(±1.2%)
Poliovirus								
≥3 Doses	85%	90%	86%	(±0.8%)	88%	(±0.8%)	90%	(±1.0%)
Hib¶								
≥3 Doses	85%	90%	91%	(±0.7%)	92%	(±0.6%)	92%	(±0.8%)
MCV**								
≥1 Dose	90%	90%	89%	(±0.7%)	90%	(±0.7%)	91%	(±0.9%)
Hepatitis B								
≥3 Doses	50%	70%	51%	(±1.1%)	68%	(±1.0%)	78%	(±1.3%)
19–24 Months	—	—	65%	(±1.3%)	75%	(±1.1%)	80%	(±2.1%)
25–30 Months	—	—	52%	(±1.3%)	70%	(±1.2%)	77%	(±2.1%)
31–35 Months	—	—	34%	(±1.3%)	57%	(±1.3%)	75%	(±2.4%)
Combined series								
4 DTP/3 Polio/1 MMR††	—	—	76%	(±1.0%)	76%	(±1.0%)	78%	(±1.3%)
4 DTP/3 Polio/1 MMR/3 Hib§§	—	—	74%	(±1.0%)	74%	(±1.0%)	76%	(±1.3%)

*Corrected estimates from previously published estimates.
†Confidence interval.
§Diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids.
¶*Haemophilus influenzae* type b vaccine.
**Any measles-containing vaccine; vaccination coverage goals are specifically for measles-mumps-rubella vaccine.
††Four doses of DTP/DT, three doses of poliovirus vaccine, and one dose of MCV.
§§Four doses of DTP/DT, three doses of poliovirus vaccine, one dose of MCV, and three doses of Hib.

In the second phase, health-care providers are contacted about eligible children in surveyed households for whom consent was obtained to verify and/or complete vaccination information. Demographic characteristics and reported vaccination histories were similar for children in households with and without provider information. For all children in the survey during 1995, vaccination information was obtained from written records for 16,067 (50%) children and from providers' records for 16,699 children (52% of all children eligible for provider follow-up). Overall, for 64% of the children in the survey, accurate vaccination information was obtained either from written records indicating receipt of the required doses for four vaccines[§] or from a provider record. As previously described, provider data were used to adjust responses for the entire group of children surveyed (*1,2,6*).

[§]DTP/DT, poliovirus vaccine, MCV, and Hib. For approximately 90% of children with such written records, provider records confirmed their up-to-date status.

Vaccination Coverage Levels — Continued

In August 1996, as part of the ongoing quality monitoring activities for this survey, all NIS vaccine data and analytic procedures were examined for accuracy and soundness. When corrections to data or changes to analytic procedures were necessary, the adjustments were made to the data for January–December 1995 and retrospectively to the previously published data for July 1994–June 1995; however, these adjustments did not substantially alter national coverage estimates for either period.

Compared with the previous reporting period (July 1994–June 1995), there were statistically significant increases during the current reporting period (January–December 1995) in national vaccination coverage with three or more doses of poliovirus vaccine (from 86% to 88%) and three or more doses of hepatitis B vaccine (from 51% to 68%) (Table 1)[¶]. Series-complete coverage estimates were unchanged for the 4:3:1 series (i.e., four doses of diphtheria and tetanus toxoids and pertussis vaccine [DTP], three doses of poliovirus vaccine, and one dose of measles-mumps-rubella vaccine [MMR]) (76%) and for the 4:3:1:3 series (i.e., four doses of DTP, three doses of poliovirus vaccine, one dose of MMR, and three doses of *Haemophilus influenzae* type b [Hib]) (74%).

For every vaccine or series of vaccines, estimated vaccination coverage for the most recent quarter (October–December 1995) was equal to or higher than that for the entire year of 1995. In addition, during the fourth quarter of 1995, the 1996 interim goals were achieved or exceeded for all routinely recommended vaccines, including hepatitis B vaccine (Table 1).

The differences in coverage with hepatitis B vaccine between older and younger children also narrowed during the 1995 reporting period. During July 1994–June 1995, coverage among children aged 19–24 months was 31 percentage points higher than coverage among children aged 31–35 months (65% versus 34%, respectively); however, for 1995, the difference decreased to 18 percentage points (75% versus 57%, respectively) and, for the fourth quarter of 1995, decreased to 5 percentage points.

During 1995, estimated state-specific coverage levels for the 4:3:1 series ranged from 66% to 89% (median: 77%) and, for the 4:3:1:3 series, ranged from 64% to 87% (median: 75%) (Table 2). Estimated coverage levels among selected large urban areas ranged from 62% to 87% (median: 75%) for the 4:3:1 series and, for the 4:3:1:3 series, ranged from 57% to 87% (median: 73%) (Table 3). Compared with July 1994–June 1995 (CDC, unpublished data, 1996), state-specific increases in coverage with the 4:3:1:3 series were largest in Colorado (from 71% to 77%), Illinois (from 73% to 79%), and Louisiana (from 70% to 76%); among urban areas, increases were largest in Newark, New Jersey (from 56% to 67%); Bexar County, Texas (from 64% to 74%); Orleans Parish, Louisiana (from 65% to 75%); and Houston, Texas (from 61% to 70%).

The 1995 CII interim goal for coverage with three or more doses of DTP was achieved by all states and 27 of the 28 urban areas, and for three or more doses of Hib vaccine, was achieved by 48 states and 27 urban areas. From the previous reporting period (July 1994–June 1995) to the current reporting period (1995), the number of states and urban areas that achieved the 1995 interim goals for three or more doses of poliovirus vaccine increased from 31 states and 16 urban areas to 44 and 21, respec-

[¶]The overlap of two quarters between the present reporting period and the previous reporting period requires a special procedure for calculating the standard error of the difference. Accounting for the overlap results in a smaller standard error than would be calculated if the reporting periods were independent.

Vaccination Coverage Levels — Continued

TABLE 2. Estimated vaccination coverage with the 4:3:1 series* and the 4:3:1:3 series†, by coverage level and state — United States, National Immunization Survey, 1995

Coverage level/ State	4:3:1 Series coverage %	(95% CI§)	Coverage level/ State	4:3:1:3 Series coverage %	(95% CI)
≥85%			**≥85%**		
Connecticut¶	85	(±4.7)	Maine	87	(±3.9)
Maine¶	89	(±3.8)	New Hampshire	86	(±3.8)
New Hampshire¶	87	(±3.8)	**75%–84%**		
Vermont¶	86	(±4.1)	Alabama	75	(±4.7)
75%–84%			Colorado	77	(±5.4)
Alabama¶	77	(±4.6)	Connecticut	83	(±4.9)
Colorado¶	78	(±5.3)	Florida	75	(±4.6)
Delaware**	75	(±5.8)	Georgia	77	(±4.9)
Florida**	76	(±4.6)	Hawaii	78	(±5.8)
Georgia¶	78	(±4.8)	Illinois	79	(±4.1)
Hawaii¶	81	(±5.5)	Indiana	75	(±4.6)
Illinois¶	81	(±4.0)	Iowa	82	(±4.4)
Indiana**	76	(±4.6)	Kentucky	79	(±5.6)
Iowa**	83	(±4.2)	Louisiana	76	(±4.7)
Kentucky**	80	(±5.5)	Maryland	78	(±4.5)
Louisiana**	77	(±4.6)	Massachusetts	80	(±4.3)
Maryland¶	81	(±4.3)	Minnesota	76	(±5.4)
Massachusetts¶	81	(±4.3)	Mississippi	81	(±5.2)
Minnesota††	77	(±5.3)	Missouri	75	(±5.7)
Mississippi††	83	(±5.0)	Nebraska	75	(±5.2)
Missouri¶	76	(±5.6)	New Mexico	76	(±5.6)
Nebraska¶	78	(±5.0)	New York	77	(±4.3)
New Jersey¶	75	(±5.3)	North Carolina	80	(±5.0)
New Mexico**	77	(±5.5)	North Dakota	81	(±4.8)
New York¶	79	(±4.2)	Pennsylvania	76	(±4.7)
North Carolina¶	81	(±5.0)	Rhode Island	82	(±4.8)
North Dakota¶	82	(±4.8)	South Carolina	80	(±4.7)
Oklahoma**	76	(±5.6)	South Dakota	79	(±4.5)
Pennsylvania¶	78	(±4.5)	Vermont	84	(±4.3)
Rhode Island¶	83	(±4.7)	Washington	77	(±4.2)
South Carolina¶	80	(±4.7)	**65%–74%**		
South Dakota§§	80	(±4.5)	Alaska	72	(±6.4)
Texas¶	76	(±3.5)	Arizona	70	(±4.9)
Washington¶	78	(±4.2)	Arkansas	73	(±5.6)
Wisconsin¶	77	(±3.8)	California	69	(±4.6)
65%–74%			Delaware	72	(±5.9)
Alaska**	74	(±6.3)	Kansas	70	(±5.8)
Arizona**	73	(±4.8)	Michigan	67	(±4.9)
Arkansas¶	74	(±5.5)	Montana	71	(±5.6)
California**	71	(±4.6)	Nevada	65	(±6.3)
Idaho**	66	(±5.9)	New Jersey	72	(±5.5)
Kansas§§	72	(±5.8)	Ohio	73	(±4.3)
Michigan**	70	(±4.8)	Oklahoma	73	(±5.7)
Montana**	74	(±5.4)	Oregon	72	(±5.8)
Nevada**	68	(±8.3)	Tennessee	73	(±4.0)
Ohio**	74	(±4.2)	Texas	73	(±3.6)
Oregon**	74	(±5.7)	Utah	66	(±5.3)
Tennessee**	74	(±4.0)	Virginia	71	(±5.9)
Utah**	68	(±5.3)	West Virginia	71	(±5.6)
Virginia**	74	(±5.8)	Wisconsin	74	(±3.9)
West Virginia††	73	(±5.6)	Wyoming	71	(±5.7)
Wyoming††	74	(±5.6)	**<65%**		
			Idaho	64	(±5.9)
Total	**76**	**(±1.0)**	**Total**	**74**	**(±1.0)**

*Four or more doses of diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT), three or more doses of poliovirus vaccine, and one or more doses of measles-containing vaccine (MCV).

†Four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of MCV, and three or more doses of *Haemophilus influenzae* type b vaccine (Hib).

§Confidence interval.

¶Achieved the 1995 Childhood Immunization Initiative (CII) goals for three or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, and three or more doses of hepatitis B vaccine.

**Achieved the 1995 CII goals for three or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, and three or more doses of Hib but not for three or more doses of hepatitis B vaccine.

††Did not achieve the 1995 CII goal for at least one of the following: three or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, or three or more doses of Hib but achieved the 1995 goal for three or more doses of hepatitis B vaccine.

§§Did not achieve the 1995 CII goal for at least one of the following: three or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, or three or more doses of Hib and did not achieve the 1995 goal for three or more doses of hepatitis B vaccine.

Vaccination Coverage Levels — Continued

TABLE 3. Estimated vaccination coverage with the 4:3:1 series* and the 4:3:1:3 series†, by coverage level and selected urban area — United States, National Immunization Survey, 1995

Coverage level/ Area	4:3:1 Series coverage %	(95% CI§)	Coverage level/ Area	4:3:1:3 Series coverage %	(95% CI)
>85%			**>85%**		
Boston, Mass.¶	87	(±4.9%)	Boston, Mass.	87	(±4.9%)
Jefferson County, Ala.¶	86	(±4.7%)	Jefferson County, Ala.	85	(±4.9%)
75%–84%			**75%–84%**		
Baltimore, Md.¶	77	(±6.8%)	Baltimore, Md.	75	(±6.9%)
Bexar County, Tex.¶	78	(±6.0%)	Dade County, Fla.	77	(±6.1%)
Dade County, Fla.¶	78	(±6.1%)	El Paso County, Tex.	77	(±5.1%)
El Paso County, Tex.**	78	(±5.1%)	Fulton/DeKalb counties, Ga.	79	(±5.8%)
Franklin County, Ohio**	76	(±5.8%)	King County, Wash.	82	(±4.7%)
Fulton/DeKalb counties, Ga.¶	83	(±5.5%)	Marion County, Ind.	75	(±6.0%)
King County, Wash.¶	83	(±4.6%)	New York City, N.Y.	78	(±6.5%)
Marion County, Ind.¶	78	(±5.7%)	Orleans Parish, La.	75	(±6.1%)
New York City, N.Y.¶	81	(±6.2%)	**65%–74%**		
Orleans Parish, La.**	77	(±6.0%)	Bexar County, Tex.	74	(±6.3%)
San Diego County, Calif.¶	75	(±6.3%)	Chicago, Ill.	69	(±6.8%)
Santa Clara County, Calif.¶	77	(±5.5%)	Cuyahoga County, Ohio	71	(±6.8%)
65%–74%			Dallas County, Tex.	70	(±6.1%)
Chicago, Ill.**	71	(±6.8%)	Davidson County, Tenn.	73	(±5.7%)
Cuyahoga County, Ohio**	74	(±6.6%)	District of Columbia	67	(±6.9%)
Dallas County, Tex.**	72	(±6.0%)	Duval County, Fla.	71	(±6.8%)
Davidson County, Tenn.**	74	(±5.6%)	Franklin County, Ohio	74	(±5.9%)
District of Columbia**	74	(±6.5%)	Houston, Tex.	70	(±6.7%)
Duval County, Fla.**	72	(±6.7%)	Los Angeles County, Calif.	70	(±7.2%)
Houston, Tex.**	73	(±6.6%)	Maricopa County, Ariz.	69	(±7.2%)
Los Angeles County, Calif.¶	73	(±7.1%)	Milwaukee County, Wis.	68	(±6.1%)
Maricopa County, Ariz.**	72	(±7.0%)	Newark, N.J.	67	(±7.3%)
Milwaukee County, Wis.¶	71	(±5.9%)	Philadelphia County, Pa.	67	(±7.4%)
Newark, N.J.**	68	(±7.3%)	San Diego County, Calif.	73	(±6.4%)
Philadelphia County, Pa.**	70	(±7.2%)	Santa Clara County, Calif.	74	(±5.7%)
Shelby County, Tenn.**	69	(±6.2%)	Shelby County, Tenn.	68	(±6.2%)
<65%			**<65%**		
Detroit, Mich.**	62	(±7.6%)	Detroit, Mich.	57	(±7.6%)

*Four or more doses of diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT), three or more doses of poliovirus vaccine, and one or more doses of measles-containing vaccine (MCV).

†Four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of MCV, and three or more doses of *Haemophilus influenzae* type b vaccine (Hib).

§Confidence interval.

¶Achieved the 1995 Childhood Immunization Initiative (CII) goals for three or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, and three or more doses of hepatitis B vaccine.

**Did not achieve the 1995 CII goal for at least one of the following: three or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, or three or more doses of Hib but achieved the 1995 goal for three or more doses of hepatitis B vaccine.

Vaccination Coverage Levels — Continued

tively, and for three or more doses of hepatitis B vaccine, the numbers increased from 20 states and 16 urban areas to 44 and 28, respectively; for one or more doses of measles-containing vaccine, the number of states that met the 1995 interim coverage goal for MMR increased from 25 to 28 but, for urban areas, decreased from 16 to 15.

Reported by: National Center for Health Statistics; Assessment Br, Data Management Div, National Immunization Program, CDC.

Editorial Note: The findings from the NIS indicate that the 1995 CII interim national coverage goals (*4*) have been achieved or exceeded for all recommended childhood vaccines. Furthermore, during the last quarter of 1995, the 1996 interim coverage goals were achieved for all these vaccines. The improvement in coverage levels for hepatitis B reflects continuing increases in coverage resulting from widespread and gradual acceptance of and adherence to the hepatitis B vaccination recommendations issued in November 1991 (*7*).

During 1995, vaccination levels among U.S. preschool-aged children were higher than ever recorded, and the number of reported cases of diphtheria, tetanus, mumps, measles, rubella, poliomyelitis, and *H. influenzae* were at or near record low levels (*8*). This substantial decline in incidence of vaccine-preventable diseases among preschool-aged children is attributable, in part, to increased vaccination coverage among this group. However, series-complete coverage with the 4:3:1 series during 1995 indicates that approximately 1 million children still require one or more of the recommended doses of vaccine to be fully protected.

Although national coverage goals have been achieved for the individual vaccines, coverage varied substantially among the states and urban areas, and many states and urban areas did not achieve the 1995 interim goals for the individual vaccines. Both the 1995 and 1996 goals of the CII were established as interim goals (for individual vaccines) toward achieving the national health objective for the year 2000 for the complete series of routinely recommended childhood vaccinations (at least 90% series-complete coverage) (objective 20.11). Series-complete goals have been more difficult to achieve than goals for individual vaccines.

The recent recommendation to include varicella vaccine in the recommended series and the persistently lower completion rate for four doses of DTP also underscore the need for intensified use of proven strategies for increasing vaccination coverage. Examples of these strategies include 1) linkage with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (*9*) and 2) assessment of vaccination coverage levels in public and private provider settings with feedback of results to individual providers (*10*).

The recent licensure of combination vaccines and the anticipated licensure of new single-antigen vaccines will further challenge the existing vaccine-delivery system. In addition, because a new birth cohort of children enters the population each year, efforts to achieve high coverage levels must begin anew each year. To benefit from these scientific advances and maintain high coverage in each successive birth cohort of children, additional components of the vaccine-delivery system need to be developed. Examples of these key components include 1) linkages between each child and a primary-care provider who is accountable for all aspects of the child's care, 2) automated vaccination registries that include both public and private providers, 3) means for ensuring financial access to vaccines, and 4) mechanisms for educating parents

Vaccination Coverage Levels — Continued

and potential parents about the importance of vaccines and for educating providers about the latest changes in vaccine recommendations (*4*).

References

1. CDC. State and national vaccination coverage levels among children aged 19–35 months—United States, April–December 1994. MMWR 1995;44:613,619–23.
2. CDC. National, state, and urban area vaccination coverage levels among children aged 19–35 months—United States, April 1994–March 1995. MMWR 1996;45:145–50.
3. CDC. National, state, and urban area vaccination coverage levels among children aged 19–35 months—United States, July 1994–June 1995. MMWR 1996;45:508–13.
4. CDC. Reported vaccine-preventable diseases—United States, 1993, and the Childhood Immunization Initiative. MMWR 1994;43:57–60.
5. Massey JT, Botman SL. Weighting adjustments for random-digit–dialed surveys. In: Groves RM, Biemer PP, Lyberg LE, Massey JT, Nicholls WL, Waksberg J. Telephone survey methodology. New York: John Wiley & Sons, 1988:143–60.
6. CDC. Sample design and procedures to produce estimates of vaccination coverage in the National Immunization Survey. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, CDC, National Immunization Program, April 18, 1996.
7. CDC. Hepatitis B virus: a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination: recommendations of the Immunization Practices Advisory Committee. MMWR 1991;40(no. RR-13).
8. Orenstein WA, Hadler S, Wharton M. Trends in vaccine-preventable diseases. Seminars in Pediatric Infectious Diseases 1997;8:23–33.
9. Birkhead GS, LeBaron CW, Parsons P, et al. The immunization of children enrolled in the Special Supplemental Food Program for Women, Infants, and Children (WIC): the impact of different strategies. JAMA 1995;274:312–6.
10. Dini E, Chaney M, Moolenaar R, LeBaron C. Information as intervention: how Georgia used vaccination coverage data to double public sector vaccination coverage in seven years. Journal of Public Health Management Practice 1996;2:45–9.

Notice to Readers

Satellite Videoconference on Viral Sexually Transmitted Diseases

Update on Viral STDs: Genital Herpes and Human Papillomavirus (HPV), a satellite videoconference, will be broadcast to sites nationwide from the St. Louis STD/HIV Prevention Training Center on March 20, 1997, from 8 a.m. to 10 a.m. eastern standard time (EST), and repeated from noon to 2 p.m. EST. Cosponsors are CDC and the St. Louis and Denver STD/HIV prevention training centers.

This program will address epidemiology, clinical aspects, counseling, and prevention of genital herpes and HPV. Toll-free telephone lines will be available for participants to ask questions regarding surveillance, epidemiology, investigation, and prevention and control of genital herpes and HPV.

Information about registration, satellite, and Continuing Medical Education and Continuing Education Units is available from the Prevention Training Center in each Public Health Region: Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont), telephone (617) 983-6945; Region II (New Jersey, New York, Puerto Rico, and Virgin Islands), telephone (518) 474-1692; Region III (District of Columbia, Delaware, Maryland, Pennsylvania, Virginia, and West Virginia), telephone (410) 396-4448; Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), telephone (205) 930-1196; Region V (Illinois,

Notice to Readers — Continued

Indiana, Michigan, Minnesota, Ohio, and Wisconsin), telephone (513) 558-3197; Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), telephone (214) 819-1947; Region VII (Iowa, Kansas, Missouri, and Nebraska), telephone (314) 747-0294; Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming), telephone (303) 436-7226; Region IX (Arizona, California, Hawaii, and Nevada), telephone (415) 554-9630; and Region X (Alaska, Idaho, Oregon, and Washington), telephone (206) 720-4222.

Errata: Vol. 46, No. RR-3

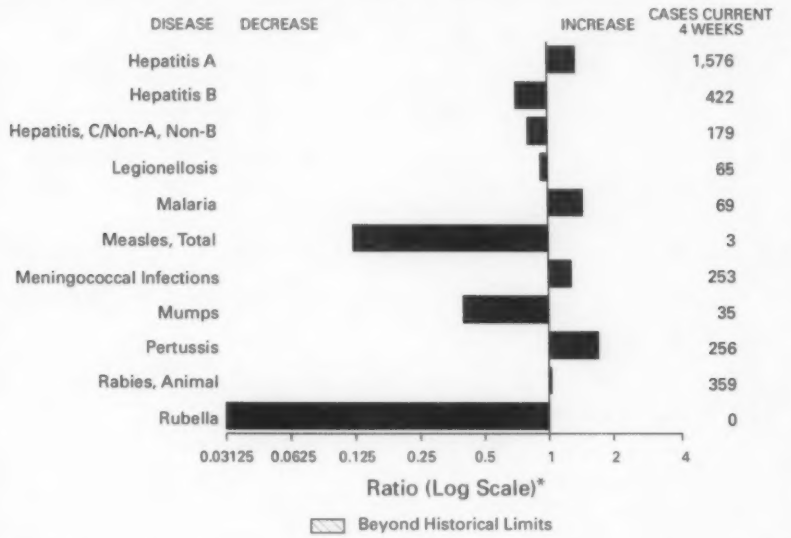
The *MMWR Recommendations and Reports* "Poliomyelitis Prevention in the United States: Introduction of a Sequential Vaccination Schedule of Inactivated Poliovirus Vaccine Followed by Oral Poliovirus Vaccine—Recommendations of the Advisory Committee on Immunization Practices (ACIP)," contained two errors. On page 14, two footnote markers on Table 4 were incorrect; below is the corrected version of Table 4. On page 25, reference number 62 should read: "Chen RT, Rastogi SC, Mullen JR, et al. The Vaccine Adverse Event Reporting System (VAERS). Vaccine 1994;*12*:542–50."

TABLE 4. Recommended poliovirus vaccination schedules for children

	Child's age			
Vaccination schedule	**2 mos.**	**4 mos.**	**12–18 mos.**	**4–6 yrs.**
Sequential IPV*/OPV†	IPV	IPV	OPV	OPV
OPV	OPV	OPV	OPV§	OPV
IPV	IPV	IPV	IPV	IPV

*Inactivated poliovirus vaccine.
†Live, oral poliovirus vaccine.
§For children who receive only OPV, the third dose of OPV may be administered as early as 6 months of age.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending February 22, 1997, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending February 22, 1997 (8th Week)

	Cum. 1997		Cum. 1997
Anthrax	-	Plague	-
Brucellosis	4	Poliomyelitis, paralytic	-
Cholera	-	Psittacosis	2
Congenital rubella syndrome	1	Rabies, human	-
Cryptosporidiosis*	132	Rocky Mountain spotted fever (RMSF)	9
Diphtheria	-	Streptococcal disease, invasive Group A	102
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	5
eastern equine*	-	Syphilis, congenital†	-
St. Louis*	-	Tetanus	3
western equine*	-	Toxic-shock syndrome	15
Hansen Disease	10	Trichinosis	2
Hantavirus pulmonary syndrome*†	-	Typhoid fever	30
Hemolytic uremic syndrome, post-diarrheal*	7	Yellow fever	-
HIV infection, pediatric*§	19		

-:no reported cases
*Not notifiable in all states.
†Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§Updated monthly to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention (NCHSTP), last update January 28, 1997.
¶Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 22, 1997, and February 24, 1996 (8th Week)

Reporting Area	AIDS*		Chlamydia		*Escherichia coli* O157:H7		Gonorrhea		Hepatitis C/NA,NB	
					NETSS†	PHLIS§				
	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1997	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996
UNITED STATES	5,109	8,408	40,296	51,563	123	43	29,827	47,252	323	422
NEW ENGLAND	134	335	2,084	2,785	13	5	762	1,174	1	10
Maine	13	7	49	-	1	-	3	4	-	-
N.H.	1	14	74	91	-	-	29	18	-	1
Vt.	7	5	56	75	1	1	9	14	-	5
Mass.	62	246	1,086	1,030	9	4	349	407	1	4
R.I.	19	9	330	351	1	-	95	82	-	-
Conn.	32	54	489	1,238	1	-	277	649	-	-
MID. ATLANTIC	1,921	2,497	2,993	3,389	8	-	1,837	4,007	28	24
Upstate N.Y.	113	323	N	N	5	-	134	3	19	20
N.Y. City	1,039	1,619	-	2,398	1	-	-	1,785	-	1
N.J.	468	416	813	1,101	2	-	521	538	-	-
Pa.	301	139	2,180	-	N	-	1,182	1,681	9	3
E.N. CENTRAL	242	718	7,114	13,651	20	8	5,083	9,356	85	72
Ohio	57	199	1,746	3,167	11	6	1,271	2,306	4	2
Ind.	25	52	1,286	1,363	2	-	991	1,088	1	-
Ill.	115	318	1,638	4,002	-	-	779	2,783	-	13
Mich.	29	106	1,991	3,992	7	1	1,748	2,355	80	57
Wis.	16	43	453	1,727	N	1	294	824	-	-
W.N. CENTRAL	127	239	2,759	4,540	20	9	1,263	2,094	16	11
Minn.	17	56	-	999	10	7	U	-	-	-
Iowa	38	22	746	183	7	-	182	86	8	2
Mo.	54	90	1,284	1,756	1	-	857	1,476	2	7
N. Dak.	2	-	81	156	2	1	5	7	1	-
S. Dak.	-	2	150	162	-	-	19	24	-	-
Nebr.	15	15	61	907	-	-	6	95	-	2
Kans.	1	54	437	737	-	1	194	406	5	-
S. ATLANTIC	1,239	1,665	10,697	6,976	11	-	12,519	16,286	32	21
Del.	20	32	-	-	-	-	146	245	-	-
Md.	166	178	786	723	-	-	1,834	2,126	4	-
D.C.	55	65	N	N	-	-	719	700	-	-
Va.	130	95	1,713	1,787	N	-	1,409	1,387	1	1
W. Va.	14	19	-	-	N	-	114	95	1	4
N.C.	59	33	2,805	U	2	-	2,514	3,136	8	6
S.C.	104	12	1,407	U	-	-	1,875	2,037	10	1
Ga.	183	215	847	1,165	4	-	1,476	3,620	U	-
Fla.	508	1,016	3,139	3,301	5	-	2,432	2,940	8	9
E.S. CENTRAL	134	328	3,545	4,192	12	3	3,654	4,808	44	75
Ky.	23	65	937	1,094	3	-	678	637	1	1
Tenn.	59	115	1,699	1,767	8	3	1,550	1,689	19	74
Ala.	37	87	909	1,291	-	-	1,426	2,111	3	-
Miss.	15	61	-	40	1	-	-	371	21	-
W.S. CENTRAL	420	868	1,896	3,655	3	1	2,032	4,498	32	43
Ark.	18	44	167	240	2	-	337	676	1	1
La.	64	171	934	-	1	1	1,028	1,322	22	8
Okla.	32	2	795	982	-	-	667	672	-	25
Tex.	306	651	-	2,433	-	-	-	1,828	9	9
MOUNTAIN	122	234	2,696	1,626	18	13	942	1,219	52	106
Mont.	7	3	95	-	-	-	7	2	3	3
Idaho	2	4	218	229	-	-	19	12	11	26
Wyo.	1	-	73	102	-	-	7	6	18	29
Colo.	24	85	U	-	12	5	230	303	10	12
N. Mex.	5	20	569	580	3	1	138	146	4	22
Ariz.	30	94	1,220	64	N	5	411	577	4	9
Utah	10	22	208	229	1	-	28	48	1	4
Nev.	43	6	313	422	2	2	102	125	1	1
PACIFIC	770	1,524	6,512	10,749	18	2	1,735	3,810	33	60
Wash.	45	65	1,339	1,484	1	-	344	396	2	11
Oreg.	30	98	220	772	3	2	39	46	3	2
Calif.	682	1,336	4,538	8,161	14	-	1,209	3,213	-	20
Alaska	10	3	206	57	-	-	78	68	-	2
Hawaii	3	22	209	275	N	-	65	87	28	25
Guam	-	3	-	59	N	-	-	17	-	-
P.R.	144	248	N	N	2	U	99	28	1	8
V.I.	4	1	N	N	N	U	-	-	-	-
Amer. Samoa	-	-	-	-	N	U	-	-	-	-
C.N.M.I.	-	-	N	N	N	U	-	7	-	-

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, last update January 28, 1997.
†National Electronic Telecommunications System for Surveillance.
§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending February 22, 1997, and February 24, 1996 (8th Week)

Reporting Area	Legionellosis		Lyme Disease		Malaria		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal
	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997
UNITED STATES	124	108	267	600	151	143	883	1,870	1,325	1,862	708
NEW ENGLAND	10	4	26	44	4	4	21	29	28	46	104
Maine	-	1	-	-	-	1	-	-	-	2	27
N.H.	2	-	1	-	-	-	-	-	2	-	2
Vt.	2	-	1	-	-	1	-	-	-	-	18
Mass.	3	1	14	-	3	2	11	12	9	15	15
R.I.	-	2	10	13	1	-	-	-	4	7	-
Conn.	3	N	-	31	-	-	10	17	13	22	42
MID. ATLANTIC	22	20	195	511	26	46	11	51	186	239	151
Upstate N.Y.	7	4	13	89	6	9	-	4	15	27	107
N.Y. City	-	-	1	184	12	23	-	18	103	100	-
N.J.	2	5	45	47	7	11	1	16	48	61	15
Pa.	13	11	136	191	1	3	10	13	20	51	29
E.N. CENTRAL	53	44	6	3	9	20	105	317	200	297	1
Ohio	32	15	6	1	1	3	40	131	60	46	-
Ind.	4	9	-	2	1	1	24	42	16	20	1
Ill.	-	3	-	-	-	8	14	83	111	199	-
Mich.	17	14	-	-	7	5	14	23	10	25	-
Wis.	-	3	U	U	-	3	13	38	3	7	-
W.N. CENTRAL	1	6	-	7	1	2	28	75	43	43	52
Minn.	-	-	-	-	-	-	-	7	17	10	9
Iowa	-	-	-	1	1	1	10	4	8	5	29
Mo.	1	2	-	1	-	1	14	56	10	16	6
N. Dak.	-	-	-	-	-	-	-	-	1	-	7
S. Dak.	-	1	-	-	-	-	-	-	1	5	-
Nebr.	-	3	-	-	-	-	-	3	-	-	-
Kans.	-	-	-	5	-	-	4	5	6	7	1
S. ATLANTIC	19	10	24	25	46	24	357	571	234	234	356
Del.	1	1	-	4	2	2	3	9	-	8	2
Md.	12	1	17	14	14	9	-	70	21	24	69
D.C.	1	1	4	-	3	1	24	15	10	10	1
Va.	-	2	-	-	8	5	44	82	16	25	64
W. Va.	-	1	-	2	-	-	-	1	7	11	6
N.C.	3	3	1	3	1	3	104	157	38	36	118
S.C.	-	1	1	-	3	-	72	71	29	41	13
Ga.	-	-	1	-	7	2	67	127	39	42	36
Fla.	2	-	-	2	8	2	43	39	74	37	47
E.S. CENTRAL	4	8	10	6	5	-	204	474	78	170	13
Ky.	-	3	1	3	1	-	20	32	14	31	6
Tenn.	1	3	2	3	1	-	118	133	9	42	-
Ala.	1	-	-	-	1	-	66	109	55	57	7
Miss.	2	2	7	-	2	-	-	200	-	40	-
W.S. CENTRAL	-	-	-	-	3	1	119	221	21	92	14
Ark.	-	-	-	-	1	-	11	47	15	12	3
La.	-	-	-	-	2	-	86	78	-	-	-
Okla.	-	-	-	-	-	-	22	22	6	17	11
Tex.	-	-	-	-	-	1	-	74	-	63	-
MOUNTAIN	9	7	-	-	9	7	21	27	40	73	2
Mont.	-	-	-	-	1	-	-	-	-	-	1
Idaho	-	-	-	-	-	-	-	1	-	1	-
Wyo.	-	-	-	-	1	-	-	-	1	-	-
Colo.	3	4	-	-	6	4	-	9	10	16	-
N. Mex.	-	-	-	-	-	1	-	-	-	6	-
Ariz.	3	1	-	-	-	1	18	14	19	43	1
Utah	3	-	-	-	-	1	-	-	1	-	-
Nev.	-	2	-	-	1	-	3	3	9	7	-
PACIFIC	6	9	6	4	48	39	17	105	495	668	15
Wash.	1	-	-	-	-	-	3	-	19	34	-
Oreg.	-	-	1	2	2	4	1	1	3	30	-
Calif.	4	9	5	2	46	34	13	103	429	572	15
Alaska	-	-	-	-	-	-	-	-	15	14	-
Hawaii	1	-	-	-	-	1	-	1	29	18	-
Guam	-	-	-	-	-	-	-	2	-	-	-
P.R.	-	-	-	-	1	-	30	23	-	-	6
V.I.	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 22, 1997, and February 24, 1996 (8th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 1997*	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	1997	Cum. 1997	1997	Cum. 1997	Cum. 1997	Cum. 1996
UNITED STATES	165	181	3,172	3,837	903	1,169	-	3	-	3	6	16
NEW ENGLAND	7	4	80	29	14	18	-	-	-	-	-	4
Maine	2	-	3	5	1	-	-	-	-	-	-	-
N.H.	1	4	4	2	1	-	-	-	-	-	-	-
Vt.	-	-	3	-	-	1	-	-	-	-	-	1
Mass.	3	-	19	12	8	1	-	-	-	-	-	3
R.I.	1	-	3	2	2	1	-	-	-	-	-	-
Conn.	-	-	28	8	2	15	-	-	-	-	-	-
MID. ATLANTIC	19	25	217	297	131	210	-	-	-	-	-	2
Upstate N.Y.	1	3	12	33	17	33	-	-	-	-	-	1
N.Y. City	7	4	88	166	50	108	-	-	-	-	-	1
N.J.	9	10	59	49	28	37	-	-	-	-	-	-
Pa.	2	8	58	49	36	32	-	-	-	-	-	-
E.N. CENTRAL	21	34	224	398	99	152	-	-	-	1	1	-
Ohio	16	18	82	164	13	19	-	-	-	-	-	-
Ind.	3	1	32	59	9	9	-	-	-	-	-	-
Ill.	-	13	-	94	-	48	-	-	-	-	-	-
Mich.	2	-	107	47	77	58	-	-	-	1	1	-
Wis.	-	2	3	34	-	18	U	-	U	-	-	-
W.N. CENTRAL	4	6	224	298	53	72	-	-	-	-	-	-
Minn.	2	-	1	3	-	2	-	-	-	-	-	-
Iowa	1	3	35	78	29	8	-	-	-	-	-	-
Mo.	1	3	130	151	16	46	-	-	-	-	-	-
N. Dak.	-	-	-	2	-	-	-	-	-	-	-	-
S. Dak.	-	-	5	10	-	-	-	-	-	-	-	-
Nebr.	-	-	11	27	1	5	-	-	-	-	-	-
Kans.	-	-	42	27	7	11	-	-	-	-	-	-
S. ATLANTIC	45	32	253	112	115	168	-	-	-	-	-	1
Del.	-	-	6	1	1	-	-	-	-	-	-	-
Md.	12	11	74	31	30	52	-	-	-	-	-	-
D.C.	2	-	7	3	6	1	-	-	-	-	-	-
Va.	2	2	24	11	11	17	-	-	-	-	-	-
W. Va.	-	-	3	4	3	6	-	-	-	-	-	-
N.C.	7	5	33	20	26	57	-	-	-	-	-	-
S.C.	4	1	13	10	7	6	-	-	-	-	-	-
Ga.	3	12	28	-	1	-	-	-	-	-	-	-
Fla.	15	1	65	32	30	29	-	-	-	-	-	1
E.S. CENTRAL	10	6	93	306	101	96	-	-	-	-	-	-
Ky.	1	1	7	4	1	7	-	-	-	-	-	-
Tenn.	9	2	45	246	60	84	-	-	-	-	-	-
Ala.	-	3	22	26	14	5	-	-	-	-	-	-
Miss.	-	-	19	30	26	U	U	-	U	-	-	-
W.S. CENTRAL	5	7	417	546	45	58	-	-	-	-	-	-
Ark.	-	-	47	80	7	8	-	-	-	-	-	-
La.	-	-	9	9	5	6	-	-	-	-	-	-
Okla.	4	7	219	302	1	8	-	-	-	-	-	-
Tex.	1	-	142	155	32	36	-	-	-	-	-	-
MOUNTAIN	9	11	627	548	131	157	-	-	-	-	-	3
Mont.	-	-	20	9	-	-	-	-	-	-	-	-
Idaho	-	1	31	70	3	17	-	-	-	-	-	-
Wyo.	-	-	3	5	7	4	-	-	-	-	-	-
Colo.	1	1	78	45	31	24	-	-	-	-	-	-
N. Mex.	1	5	49	93	46	65	-	-	-	-	-	-
Ariz.	4	2	263	151	26	15	-	-	-	-	-	-
Utah	1	1	158	128	15	25	-	-	-	-	-	-
Nev.	2	1	25	47	3	7	-	-	-	-	-	3
PACIFIC	45	56	1,057	1,303	214	238	-	3	-	2	5	6
Wash.	-	-	60	65	4	11	-	-	-	-	-	1
Oreg.	7	7	71	208	23	22	-	-	-	-	-	-
Calif.	36	47	895	1,000	180	203	-	-	-	2	2	-
Alaska	-	-	5	11	4	1	-	-	-	-	-	4
Hawaii	2	2	26	19	3	1	-	3	-	-	3	1
Guam	-	-	-	2	-	-	U	-	U	-	-	-
P.R.	-	-	13	11	27	18	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	-	-	-	-	-	-	U	-	U	-	-	-
C.N.M.I.	-	10	-	1	-	3	U	-	U	-	-	-

N: Not notifiable U: Unavailable -: no reported cases

*Of 29 cases among children aged <5 years, serotype was reported for 8 and of those, 5 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 22, 1997, and February 24, 1996 (8th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 1997	Cum. 1996	1997	Cum. 1997	Cum. 1996	1997	Cum. 1997	Cum. 1996	1997	Cum. 1997	Cum. 1996
UNITED STATES	535	634	8	57	89	72	574	288	-	1	18
NEW ENGLAND	34	29	-	1	-	6	158	89	-	-	-
Maine	4	6	-	-	-	-	4	2	-	-	-
N.H.	3	1	-	-	-	2	29	6	-	-	-
Vt.	1	1	-	-	-	4	71	6	-	-	-
Mass.	20	7	-	-	-	-	49	55	-	-	-
R.I.	1	5	-	1	-	-	5	-	-	-	-
Conn.	5	9	-	-	-	-	-	-	-	-	-
MID. ATLANTIC	40	53	-	4	14	2	22	35	-	1	2
Upstate N.Y.	6	7	-	-	5	-	11	24	-	-	-
N.Y. City	8	9	-	-	2	-	2	7	-	1	1
N.J.	11	12	-	-	2	-	-	2	-	-	1
Pa.	15	25	-	4	5	2	9	2	-	-	-
E.N. CENTRAL	47	81	-	10	24	6	57	65	-	-	-
Ohio	33	32	-	3	13	3	37	31	-	-	-
Ind.	10	8	-	4	1	2	2	3	-	-	-
Ill.	-	25	-	1	5	-	3	5	-	-	-
Mich.	4	4	-	2	5	1	15	5	-	-	-
Wis.	-	12	U	-	-	U	-	21	U	-	-
W.N. CENTRAL	45	61	1	3	2	9	30	5	-	-	-
Minn.	2	3	1	1	-	8	18	1	-	-	-
Iowa	11	11	-	2	-	1	9	-	-	-	-
Mo.	17	31	-	-	-	-	-	3	-	-	-
N. Dak.	-	1	-	-	2	-	1	-	-	-	-
S. Dak.	3	2	-	-	-	-	1	-	-	-	-
Nebr.	3	5	-	-	-	-	1	1	-	-	-
Kans.	9	8	-	-	-	-	-	-	-	-	-
S. ATLANTIC	121	87	4	9	11	18	53	23	-	-	-
Del.	2	1	-	-	-	-	-	-	-	-	-
Md.	10	11	-	-	5	1	26	18	-	-	-
D.C.	1	2	-	-	-	-	2	-	-	-	-
Va.	6	11	-	1	2	2	4	-	-	-	-
W. Va.	1	3	-	-	-	2	3	-	-	-	-
N.C.	23	15	1	1	-	11	11	-	-	-	-
S.C.	25	16	1	1	3	-	2	-	-	-	-
Ga.	21	23	-	-	1	-	-	1	-	-	-
Fla.	32	5	2	6	-	2	5	4	-	-	-
E.S. CENTRAL	49	52	-	6	4	3	16	8	-	-	-
Ky.	7	7	-	-	-	1	1	5	-	-	-
Tenn.	20	14	-	2	1	2	5	1	-	-	-
Ala.	17	17	-	2	3	-	6	1	-	-	-
Miss.	5	14	U	2	-	U	4	1	U	-	N
W.S. CENTRAL	34	73	1	4	3	1	5	3	-	-	-
Ark.	9	8	-	-	-	-	3	2	-	-	-
La.	12	16	-	-	3	1	1	1	-	-	-
Okla.	5	3	-	-	-	-	-	-	-	-	-
Tex.	8	46	1	4	-	-	1	-	-	-	-
MOUNTAIN	31	42	-	2	3	10	133	29	-	-	-
Mont.	2	1	-	-	-	-	-	2	-	-	-
Idaho	3	3	-	-	-	2	83	-	-	-	-
Wyo.	-	3	-	-	-	-	3	-	-	-	-
Colo.	2	4	-	1	-	7	36	-	-	-	-
N. Mex.	7	10	N	N	N	1	7	10	-	-	-
Ariz.	11	13	-	-	-	-	4	3	-	-	-
Utah	4	3	-	1	-	-	-	1	-	-	-
Nev.	2	5	-	-	3	-	-	13	-	-	-
PACIFIC	134	156	2	18	28	17	100	51	-	-	16
Wash.	12	9	1	3	2	11	24	6	-	-	-
Oreg.	34	26	-	-	-	-	3	15	-	-	-
Calif.	87	117	1	11	19	6	70	27	-	-	16
Alaska	-	2	-	-	1	-	1	-	-	-	-
Hawaii	1	2	-	4	6	-	2	3	-	-	-
Guam	-	1	U	-	1	U	-	-	U	-	-
P.R.	1	-	-	-	-	-	-	-	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	-	U	-	-	U	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE IV. Deaths in 122 U.S. cities,* week ending February 22, 1997 (8th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	634	472	103	34	14	11	55
Boston, Mass.	126	77	27	14	3	5	10
Bridgeport, Conn.	46	36	5	3	1	1	4
Cambridge, Mass.	25	19	4	2	-	-	5
Fall River, Mass.	30	28	1	-	1	-	2
Hartford, Conn.	82	50	20	7	4	1	2
Lowell, Mass.	16	13	2	1	-	-	1
Lynn, Mass.	16	12	4	-	-	-	3
New Bedford, Mass.	24	22	2	-	-	-	3
New Haven, Conn.	32	22	7	-	-	3	1
Providence, R.I.	83	62	15	4	2	-	6
Somerville, Mass.	3	3	-	-	-	-	-
Springfield, Mass.	62	52	7	2	1	-	7
Waterbury, Conn.	29	25	3	-	1	-	1
Worcester, Mass.	60	51	6	1	1	1	10
MID. ATLANTIC	2,262	1,538	450	198	39	37	130
Albany, N.Y.	46	36	7	1	2	-	1
Allentown, Pa.	28	22	5	1	-	-	2
Buffalo, N.Y.	U	U	U	U	U	U	U
Camden, N.J.	42	26	8	4	-	4	1
Elizabeth, N.J.	21	16	3	1	1	-	1
Erie, Pa.	53	46	4	2	-	1	7
Jersey City, N.J.	49	33	9	6	-	1	1
New York City, N.Y.	1,230	829	262	101	21	17	55
Newark, N.J.	66	25	18	19	3	1	2
Paterson, N.J.	22	14	6	1	1	-	-
Philadelphia, Pa.	299	184	65	37	10	3	15
Pittsburgh, Pa.§	55	37	13	4	-	1	8
Reading, Pa.	10	8	2	-	-	-	1
Rochester, N.Y.	132	102	13	12	1	4	14
Schenectady, N.Y.	26	23	3	-	-	-	1
Scranton, Pa.	31	24	4	3	-	-	4
Syracuse, N.Y.	70	55	12	2	-	1	8
Trenton, N.J.	38	27	6	1	-	4	7
Utica, N.Y.	22	19	3	-	-	-	-
Yonkers, N.Y.	22	12	7	3	-	-	2
E.N. CENTRAL	2,308	1,584	416	182	62	61	120
Akron, Ohio	63	48	9	5	1	-	-
Canton, Ohio	46	36	3	6	-	1	4
Chicago, Ill.	576	340	126	72	19	16	46
Cincinnati, Ohio	125	92	17	8	3	5	12
Cleveland, Ohio	121	84	20	8	2	7	3
Columbus, Ohio	215	153	45	10	2	5	10
Dayton, Ohio	114	79	20	9	5	1	10
Detroit, Mich.	221	137	51	19	7	7	4
Evansville, Ind.	48	37	8	3	-	-	3
Fort Wayne, Ind.	79	60	12	4	2	1	1
Gary, Ind.	9	3	4	2	-	-	-
Grand Rapids, Mich.	45	33	5	3	1	3	2
Indianapolis, Ind.	218	146	44	10	10	8	-
Lansing, Mich.	42	25	12	3	2	-	3
Milwaukee, Wis.	117	94	14	6	-	3	7
Peoria, Ill.	39	35	1	1	-	2	3
Rockford, Ill.	53	39	8	4	2	-	3
South Bend, Ind.	52	44	2	4	2	-	4
Toledo, Ohio	78	60	10	3	3	2	4
Youngstown, Ohio	47	39	5	2	1	-	1
W.N. CENTRAL	912	670	145	49	19	23	64
Des Moines, Iowa	135	101	25	6	1	2	15
Duluth, Minn.	30	22	7	1	-	-	2
Kansas City, Kans.	28	16	7	5	-	-	1
Kansas City, Mo.	114	74	20	8	3	3	6
Lincoln, Nebr.	50	39	9	1	-	1	1
Minneapolis, Minn.	221	177	25	8	2	9	14
Omaha, Nebr.	92	65	12	8	4	3	7
St. Louis, Mo.	106	77	20	4	4	1	10
St. Paul, Minn.	67	49	11	5	1	1	6
Wichita, Kans.	69	50	9	3	4	3	2
S. ATLANTIC	1,275	831	253	126	43	20	86
Atlanta, Ga.	165	117	27	18	2	1	8
Baltimore, Md.	271	178	49	31	7	5	31
Charlotte, N.C.	U	U	U	U	U	U	U
Jacksonville, Fla.	137	96	23	10	7	1	5
Miami, Fla.	128	80	33	13	1	1	-
Norfolk, Va.	47	34	11	-	2	-	4
Richmond, Va.	67	39	19	5	3	1	1
Savannah, Ga.	61	47	10	3	-	1	9
St. Petersburg, Fla.	48	36	5	5	1	1	6
Tampa, Fla.	224	143	43	20	12	5	19
Washington, D.C.	119	58	28	21	8	4	3
Wilmington, Del.	8	3	5	-	-	-	-
E.S. CENTRAL	752	514	151	52	12	22	63
Birmingham, Ala.	10	3	3	2	-	1	-
Chattanooga, Tenn.	76	55	15	4	-	2	6
Knoxville, Tenn.	70	49	13	4	2	2	13
Lexington, Ky.	85	57	20	4	1	3	3
Memphis, Tenn.	177	128	30	13	6	-	18
Mobile, Ala.	119	78	26	9	2	4	2
Montgomery, Ala.	67	46	10	7	-	4	3
Nashville, Tenn.	148	98	34	9	1	6	18
W.S. CENTRAL	1,589	1,061	283	151	46	48	101
Austin, Tex.	89	62	16	9	-	2	8
Baton Rouge, La.	46	35	4	5	1	1	1
Corpus Christi, Tex.	61	46	6	2	2	5	6
Dallas, Tex.	190	114	41	19	8	8	5
El Paso, Tex.	80	60	11	4	3	2	5
Ft. Worth, Tex.	134	97	22	9	3	3	8
Houston, Tex.	354	229	74	33	10	8	27
Little Rock, Ark.	68	41	12	10	-	5	2
New Orleans, La.	141	91	22	19	6	3	-
San Antonio, Tex.	223	157	38	21	1	6	15
Shreveport, La.	74	53	15	3	2	1	13
Tulsa, Okla.	129	76	22	17	10	4	11
MOUNTAIN	886	610	165	66	33	10	79
Albuquerque, N.M.	108	67	21	11	7	2	6
Boise, Idaho	U	U	U	U	U	U	U
Colo. Springs, Colo.	61	42	14	2	3	-	2
Denver, Colo.	99	58	27	9	3	2	10
Las Vegas, Nev.	160	103	31	15	7	2	10
Ogden, Utah	25	23	1	1	-	-	1
Phoenix, Ariz.	134	99	21	8	6	-	13
Pueblo, Colo.	20	16	4	-	-	-	2
Salt Lake City, Utah	92	62	17	9	3	1	12
Tucson, Ariz.	187	140	29	11	4	3	23
PACIFIC	1,448	1,076	236	96	21	19	135
Berkeley, Calif.	13	10	2	1	-	-	-
Fresno, Calif.	79	61	12	3	-	3	15
Glendale, Calif.	12	10	1	1	-	-	1
Honolulu, Hawaii	67	53	8	5	1	-	3
Long Beach, Calif.	66	45	10	6	3	2	4
Los Angeles, Calif.	296	216	55	15	6	4	18
Pasadena, Calif.	22	18	2	1	-	1	2
Portland, Oreg.	124	89	24	10	-	1	7
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	124	88	21	13	1	1	18
San Francisco, Calif.	132	96	24	9	3	-	25
San Jose, Calif.	207	150	37	15	2	3	19
Santa Cruz, Calif.	28	26	2	-	-	-	2
Seattle, Wash.	135	103	21	9	1	1	2
Spokane, Wash.	53	42	6	2	1	2	8
Tacoma, Wash.	90	69	11	6	3	1	11
TOTAL	12,066¶	8,356	2,202	954	289	251	833

U: Unavailable -: no reported cases

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

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The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/* or from CDC's file transfer protocol server at *ftp.cdc.gov*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (404) 332-4555.

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HEALTH AND HUMAN SERVICES
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and Prevention (CDC)
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